SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115
(605) 362-2760 ♦ FAX: 362-2768

REGISTERED NURSE (RN) & LICENSED PRACTICAL NURSE (LPN) LICENSURE RENEWAL INSTRUCTIONS & FORMS

Please submit your renewal forms and renewal fee well in advance of your expiration date to avoid lapsing of your license. It is illegal to practice nursing in this state without a valid license. All forms and fees must be postmarked on or before your expiration date to avoid lapsing.

A cashier's check or money order are the preferred methods of payment for the Renewal fee.
A $20 fee will be charged for any insufficient check written to the Board of Nursing.

Along with the $90 Renewal fee, please complete and submit the three forms that follow:

- RENEWAL APPLICATION / DISCIPLINARY INFORMATION / DECLARATION OF RESIDENCE/AFFIDAVIT
- NURSE SURVEY QUESTIONNAIRE
- VERIFICATION OF EMPLOYMENT

Employment or volunteer work is defined as practice of nursing for at least
140 hours in any 12 month period during the preceding 6 years, or
the total accumulation of 480 hours during the preceding 6 years.
If you cannot provide such Verification of Employment or volunteer work, you will be required to place your nursing license on inactive or meet the re-entry standards as per ARSD 20:48:03:16.

INACTIVE STATUS: Should you wish to place your nursing license on inactive status, please submit the following before you nursing license expires:

- A written request to place your nursing license on inactive.
- $10 inactivation fee.

ADVANCED PRACTICE ALERT: To practice in South Dakota as a Certified Nurse Midwife (CNM), Certified Nurse Practitioner (CNP), Clinical Nurse Specialist (CNS), or Certified Registered Nurse Anesthetist (CRNA), you must hold two licenses – one as a Registered Nurse, and one as a CNM, CNP, CNS, or CRNA. You must complete a separate Advanced Practice Renewal Application and pay a separate Advanced Practice Licensure Renewal fee. Renewal forms are available from the Board of Nursing office and also at the Board website.

Please feel free to contact the Board office if you have any questions.

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$90 RENEWAL FEE

RENEWAL APPLICATION FOR RN / LPN LICENSURE

APPLICANT NAME: _____
FIRST MIDDLE MAIDEN LAST OTHER NAMES

ADDRESS: _____
STREET OR PO BOX CITY COUNTY STATE ZIP

SOCIAL SECURITY # _____ LICENSE # _____ ❒MALE ❒FEMALE

DATE OF BIRTH: _____ TELEPHONE: _____ EMAIL: _____

ETHNICITY: ❒White ❒Black ❒Hispanic ❒Asian/Pacific Islander ❒American Indian/Alaskan Native ❒Other:

PLEASE LIST ALL STATES IN WHICH YOU CURRENTLY PRACTICE: _____

DISCIPLINARY INFORMATION

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? **If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and All communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.**	❒YES	❒NO
2.	Is there any pending criminal prosecution against you which would constitute a felony?	❒YES	❒NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	❒YES	❒NO
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	❒YES	❒NO
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	❒YES	❒NO
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	❒YES	❒NO
7.	Within the last two years, have you been treated for abuse or misuse of any alcohol or chemical substance?	❒YES	❒NO
8.	Within the last two years, have you experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	❒YES	❒NO
9.	Do you currently owe child support arrearages in the sum of $1,000 or more?	❒YES	❒NO

For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.

DECLARATION OF PRIMARY STATE OF RESIDENCE – AND – AFFIDAVIT

❒ I declare that my primary state of residence (where I hold a driver's license, pay taxes, and or/vote) is _____.
This is my "home state" under the Nurse Licensure Compact and is my "declared fixed permanent and principal home for legal purposes."
- OR -
❒ I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: _____.

I further declare and affirm under penalties of perjury that this application for nurse licensure in South Dakota has been examined by me, and, to the best of my knowledge and belief, is in all things true and correct.

Applicant Signature: _____ Date: _____.

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VERIFICATION OF EMPLOYMENT

APPLICANT: *Please complete the top half of this form and then forward it to your employer or former employer. This form may be duplicated for additional employment verifications. Return the completed form(s) to the South Dakota Board of Nursing.*

To obtain/retain active licensure, a nurse must provide verification of employment/volunteer work in nursing of at least

- 140 hours in any 12 month period during the preceding 6 years, or
- the total accumulation of 480 hours during the preceding 6 years.

APPLICANT NAME: _____
FIRST MIDDLE MAIDEN LAST OTHER NAME(S)

ADDRESS: _____
STREET CITY STATE ZIP

SOCIAL SECURITY # _____ LICENSE # _____

❒ I have been employed/volunteered as a: ◊RN ◊LPN ◊CNM ◊CNP ◊CNS ◊CRNA
❒ I have not been employed/volunteered as a nurse within the last six years.
❒ I choose to apply verification of employment/volunteer work filed with the Board within the last 6 years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for licensure purposes.

_____ _____
SIGNATURE OF APPLICANT DATE

THIS SECTION TO BE COMPLETED BY EMPLOYER
NOTE: THIS SECTION CANNOT BE SIGNED BY THE APPLICANT

The above named individual was employed/volunteered as a nurse

from _____ **to** _____
MONTH / DATE / YEAR MONTH / DATE / YEAR

Total hours during this period: _____

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for licensure purposes is true and correct.

_____ _____
SIGNATURE OF AGENCY REPRESENTATIVE/TITLE DATE
WHO CAN VERIFY/CONFIRM NUMBER OF HOURS EMPLOYED/VOLUNTEERED

Name of Employer: _____

Address of Employer: _____

Telephone: _____ Email: _____

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NURSE SURVEY QUESTIONNAIRE

Please circle ONE number in each category below that best represents your current practice.

Survey Date: _____

EMPLOYMENT STATUS	
1	Full-Time Nurse
2	Part-Time Nurse
3	Full-Time other than Nursing
4	Part-Time other than Nursing
5	Volunteer Nurse
6	Unemployed
7	Retired Nurse

WHERE PRESENTLY EMPLOYED	
County:	
State:	
City:	
Zip Code:	

TYPE OF POSITION	
1	Nurse Management
2	Consultant
3	Case Manager
4	Nursing Program Faculty
5	Clinic Nurse
6	Staff Nurse
7	Advanced Practice Nurse (CRNA, CNP, CNM, CNS)
8	Charge Nurse
9	Inservice Educator/Staff Development
10	Other:

ADVANCED PRACTICE NURSES ONLY	
1	Certified Registered Nurse Anesthetist (CRNA)
2	Certified Nurse Practitioner (CNP)
3	Certified Nurse Midwife (CNM)
4	Clinical Nurse Specialist (CNS)

FORMAL EDUCATION ACTIVITIES	
1	I am not taking courses toward an advanced degree in nursing
2	I am currently taking courses toward an advanced degree in nursing

PRINCIPAL FIELD / PLACE OF EMPLOYMENT	
1	Hospital
2	Nursing Home / Long Term Care
3	Nursing Education Program
4	Home Health / Hospice
5	School
6	Outpatient Surgical Center
7	Office / Clinic
8	Community Health
9	Self-Employed
10	Other:

HIGHEST DEGREE HELD	
1	Diploma / Registered Nurse
2	Associate Degree / Registered Nurse
3	Baccalaureate Degree / Registered Nurse
4	Baccalaureate in other field
5	Masters in Nursing
6	Masters in other field
7	Doctorate (PhD, Ed, DNSc)
8	Diploma / Associate Degree / Practical Nurse

WHAT PERCENT OF YOUR CURRENT POSITION INVOLVES DIRECT PATIENT CARE?									
1	0%	2	25%	3	50%	4	75%	5	100%

DO YOU INTEND TO LEAVE/RETIRE FROM NURSING PRACTICE IN THE NEXT 5 YEARS?			
1	Yes	2	No

STATES OTHER THAN SD IN WHICH YOU ARE LICENSED: _____